State of Maine

STATE BOARD OF EXAMINERS OF PSYCHOLOGISTS

Application information to assist in completing your application. This information is not designed to include all information on laws and rules and it is strongly recommended that you review applicable laws and rules.

Psychological Examiner Applying to take the EPPP

Do not return the following informational pages with your application; it is for your information only

Department of Professional and Financial Regulation
Office of Professional and Occupational Regulation
(Mailing address) 35 State House Station, Augusta, ME 04333
(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345
Note: The office location address may be used for overnight deliveries only. The office address does not accept postal deliveries. You must use the mailing address for all other regular mail deliveries.

Office Direct Line (207) 624-8689 or Main Receptionist (207) 624-8603
TTY users call Maine relay 711
FAX (207) 624-8637
Web address: www.maine.gov/professionallicensing
Email: psych.lic@maine.gov

Published under appropriation 01402A4410012 Revised 04/2014
35 State House Station, Augusta ME 04333 Website: www.maine.gov/professionallicensing

APPLICATION INSTRUCTIONS
PSYCHOLOGICAL EXAMINER

Fax submissions of applications and supporting documentation <u>will not be accepted.</u>

<u>INITIAL EACH PAGE OF YOUR APPLICATION WHERE NOTED.</u> Be sure to initial the bottom of each page where noted on your application. This is critical to insuring that each page of your application is intact with the correlating application and will help us with expediting your application review.

✓ Information checklist for documents to be submitted to the Board in one package at time of application. (This is an abbreviated checklist and does not replace the requirements outlined in the Psychologists Laws and Rules. Please review them carefully for more detailed and clarifying information.)

□ **Completed Application**
Complete and sign the application. Submit with appropriate fees and documentation.

□ **Official, sealed transcript from graduate program where qualifying degree was earned.**

□ **Documentation of Supervised Work Experience, on forms supplied by board.**
Minimum 1500 hours (Review Chapter 5)

□ **Three letters of recommendation.**
In accordance with Chapter 3, section 1(3)(A)(3) of the Board's rules.

□ **Examination – EPPP**
Please provide scores.

Upon approval by this office that you are qualified to take the EPPP, we will notify the testing company. <u>You must provide a valid email address for the testing company to contact you</u>. Exam scores are reported directly by electronic means to this office from the testing company. You will be notified of the score in writing. **Please allow at least 30 days from test date.**

□ **Any other supporting documentation such as: verification of licensure or criminal conviction information**
Submit verification from every state in which you currently hold or have ever held any type of professional license (except Maine).

Court judgment and decision of any criminal conviction and a written statement regarding the crime.

CONTINUING EDUCATION
As a Psychologists you will be required to satisfy the Continuing Education requirements identified in Chapter 8 of the Board's rules. Please be sure to review this chapter carefully.

<u>IMPORTANT NOTE:</u>

✓ Application reviews can take up to 3 months. All applications are presented to the Board for approval. Please review the schedule of meetings on the website to plan your licensure process accordingly. Please note meeting dates are always subject to change.

✓ All persons applying for a Maine license must take and pass the Maine jurisprudence examination. Once your completed application has been reviewed and approved by the Board, you will be sent the jurisprudence exam via Certified mail and you will have 20 days to complete and return.

IMPORTANT NOTES:

The Board of Examiners requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered (including the use of any white out substance) in any way will not be accepted.

✓ Your application has greater chance of being processed expeditiously if it is complete and all supporting documents are attached. Action on this application is posted to the web in real time. Please visit our website if you wish to monitor progress. If the status appears as Pending, this means that your application was received by this office and it is pending or under review. Once reviewed and if everything about your application is complete and complies with requirements, the license will be issued and the status will show as ACTIVE. If incomplete and a letter is being sent to you, the letter will be available for you to see online.

✓ Please refrain from calling our office to "check" on your application as these calls only serve to slow our ability to review and process applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation's website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.

✓ Once your license is issued it is immediately visible online with an "active" status. Licenses are printed off site and require at least 14 business days for delivery.

SUGGESTED REFERENCE MATERIAL FOR THE JURISPRUDENCE EXAMINATION

The test is based on the documents listed below. Copies of these documents are available as noted. You must print documents from the websites listed as these materials will **not** be provided. You may bring your copies to the examination.
The following laws and rules can be found by clicking on the "Laws & Rules" link on our website at www.maine.gov/professionallicensing.

⇒ The Maine Board of Examiners of Psychologists Law - 32 MRS Chapter 56
⇒ The Maine Board of Examiners of Psychologists Rules - Chapters 1 through 10
⇒ 10 MRS, Chapter 901
⇒ Laws Related to the Practice of Psychology in Maine:
  22 MRS Chapter 958-A
  22 MRS Chapter 1071
  34-B MRS Chapter 3, Subchapter IV

The following related material can be found at the websites listed.
Codes of Conduct:
⇒ Ethical Principles of Psychologists and Code of Conduct (APA 2002)
  Via Internet: www.apa.org/ethics
⇒ Code of Conduct (ASPPB, 2005)
  Via Internet: www.asppb.org/publications/model/conduct.aspx
⇒ Maine Rules of Evidence – Rule 503
  Via Internet: http://www.courts.state.me.us/rules_adminorders/rules/text/MREvidONLY1-12.pdf

VERIFICATION OF LICENSURE IN ANOTHER STATE OR JURISDICTION

If you hold or have held a professional license in another state or jurisdiction, you must submit evidence from the State of licensure in the form of a License Verification. Please contact the state of licensure to request an official License Verification. At a minimum, the license verification must contain:

- Name of State providing the License Verification
- Your name
- License number and expiration date
- Status of your license i.e. active, inactive, lapsed, probation, restricted, suspended, revoked
- Type of license issued to you
- Date your license was issued
- If appropriate, hours of internship completed with beginning and ending dates
- Method your license was issued i.e. Original State, Reciprocity/Endorsement, Score Transfer
- Examinations taken i.e. EPPP, Jurisprudence, other
- Disciplinary action(s) against your license, if any
- Signature and title of person from the licensing jurisdiction providing License Verification
- State Seal

Please direct the licensing jurisdiction to send the License Verification report to you directly and in turn you must submit this verification with your completed Maine application.

A sample license verification is available on the Board's website in the applications and forms section.

IMPORTANT: Applications submitted without **all of the Verifications of Licensure** from the licensing jurisdiction(s) will not be accepted and your application returned as incomplete.

You may also obtain an electronically produced License Verification directly from the State Board website. Please be sure each License Verification contains the State web-address, the date the License Verification was printed, and a disciplinary history.

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION - OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
Mailing Address: 35 State House Station, Augusta, Maine 04333 **Courier/Delivery address**: 76 Northern Avenue, Gardiner, Maine 04345
Phone: (207) 624-8603 Fax: (207) 624-8637 TTY users call Maine relay 711 web: www.maine.gov/professionallicensing

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 AM to 5:00 PM weekdays
- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.
- **Can I come to Gardiner to pick up my license?** No. Your license will be mailed to you.
- **How long does it take to process an application?** You can check our website: www.maine.gov/professionallicensing. Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.
- **How far back do I go answering the criminal question?** Any conviction, ever.

NOTICES

BACKGROUND CHECK: Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Professional and Occupational Regulation requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974. Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 36 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(c)(2)(C)(i)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Answer the criminal background disclosure questions
- Sign and date your application
- Include correct amount (payable to Maine State Treasurer) *or* credit card information (plus signature)
- Include any required transcripts or exam results
- Make a copy of your application to keep for your records
- DO NOT SEND CASH.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
INDIVIDUAL LICENSE APPLICATION

APPLICANT INFORMATION (please print)			
FULL LEGAL NAME	*FIRST*	*MIDDLE INITIAL*	*LAST*
ANY OTHER NAMES EVER USED:			
DATE OF BIRTH *mm / dd / yyyy*		SOCIAL SECURITY NUMBER - -	
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ( )	FAX # ( )	E-MAIL	

CRIMINAL BACKGROUND DISCLOSURE

NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.

1. **Have you ever been convicted by any court of any crime?**
   (circle one) NO YES

   If yes, enclose a signed detailed description of what happened (including dates) and a copy of the court judgment.

2. **Has any jurisdiction taken disciplinary action against any professional license you hold or have held, or denied your application for licensure? (circle one) NO YES**

   If yes, enclose a signed detailed explanation and copies of all documents.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional and Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

SIGNATURE **DATE**

State Board of Examiners of Psychologists
Psychological Examiner Applying to take the EPPP
Required Fees: $321.00 (Non-Refundable)

(includes EPPP examination processing, jurisprudence examination, license and criminal records check fee)

LICENSE TYPE:

☐ Psychological Examiner *(PE1421)*

Office Use Only:

PE 1447 - $100.00
1421 - $200.00
2619 - $ 21.00

Office Use Only:

Check #_____
Amount:_____
Cash #_____
Lic. #_____
Issue Date_____
Exp. Date_____

PAYMENT OPTIONS:

Make checks payable to "Maine State Treasurer" - If you wish to pay by Mastercard or Visa, fill out the following:

NAME OF CARDHOLDER (please print) *FIRST* *MIDDLE INITIAL* *LAST*

I authorize the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation to charge my ☐ VISA ☐ MASTERCARD the following amount: $_____

☐ **I understand that fees are non-refundable**

Card number: *XXXX-XXXX-XXXX-XXXX* Expiration Date *mm / yyyy*

SIGNATURE **DATE**

SECTION 1: EDUCATION

Please check all that apply:		
☐ Ed. M. Master's of Education ☐ M.ED. Master's of Education ☐ Ed. D Doctor of Education ☐ M.S.E.D. Master's of Science in Education ☐ M.S. Master's of Science ☐ M.A. Master's of Arts ☐ Ph.D. Doctor of Philosophy ☐ Psy.D. Doctor of Psychology ☐ APA accredited ☐ NASP Accredited ☐ ASPPB/NR accredited ☐ Non Accredited Educational Program Other describe: _____		
Name of Educational Provider		Date of Graduation
Contact Address: Street or P.O. Box		
City	State	Zip Code
Official sealed transcript demonstrating your education must be submitted with your application.		

SECTION 2: LIST BELOW EVERY JURISDICTION IN WHICH YOU HOLD OR HAVE EVER HELD A PROFESSIONAL LICENSE, INCLUDING PSYCHOLOGIST, PSYCHOLOGICAL EXAMINER, OR OTHER MENTAL HEALTH PROFESSIONAL LICENSES.

1. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
2. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
3. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
For each of the above, you must submit with this application an official Verification of Licensure from the licensing jurisdiction. IMPORTANT: Applications submitted without all of the Verification of Licensure from the licensing jurisdiction(s) will not be accepted and your application returned as incomplete.			

Use a separate sheet of paper if additional space is needed.

_____ INITIALS OF APPLICANT

SECTION 3: EXAMINATION

Have you ever taken a licensing examination?

If yes, list the jurisdiction(s) where you took the examination, type of examination, date of examination and score:

Jurisdiction	Examination Type	Date	Score
EPPP			

☐ Yes

☐ No

SECTION 4: CHECK APPROPRIATE RESPONSE TO THE QUESTIONS BELOW. ANY YES RESPONSE MUST BE FULLY EXPLAINED BY WRITTEN STATEMENT ON A SEPARATE SHEET OF PAPER, SIGNED AND DATED, AND SUBMITTED WITH YOUR APPLICATION.

Have hospital or similar health care institution privileges ever been denied or suspended, restricted or withdrawn involuntarily; or have you ever voluntarily surrendered privileges or resigned from staff membership while under peer review?

☐ Yes

☐ No

Have you ever received a sanction from Medicare or from a state Medicaid program?

1. ☐ Medicare OR ☐ Medicaid Program (State) _____
2. Submit a copy of the official action by the entity.
3. Provide a detailed explanation in your own words on a separate sheet of paper.

Clarification on programs:

- Medicare – Health program administered by the United States government for people that are (1) ages 65 or older, (2) under the age of 65 with certain disabilities, and/or (3) all ages with end-stage renal disease.
- Medicaid – Health program administered by the United States government for people with limited incomes.
- MaineCare – Health program administered by the State of Maine with similar eligibility requirements as Medicaid.

☐ Yes

☐ No

Do you currently have any physical or mental impairment related to drugs, alcohol, or finding of mental incompetence that would limit your ability to undertake the practice of psychology safely?

☐ Yes

☐ No

_____ INITIALS OF APPLICANT

SECTION 5: NOTICES

Please Note:

Pursuant to 10 MRS §8003-G - any change in name, address, email address, criminal convictions, disciplinary actions, or any material change set forth in your original application for licensure must be reported to the Office within 10 days. You can access this Law for your review at: http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html

SECTION 6: APPLICANT'S CERTIFICATION AND SIGNATURE

Read the statement below and sign where indicated as your certification of the information provided on this application. Applications that are incomplete, altered (including use of any white out), defaced, or compromised will not be accepted and will be returned. This includes, but is not limited to, unanswered questions, lack of appropriate signature, information is illegible, missing required supporting documents, and/or missing or wrong fee.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

Printed Name of Applicant	Title
Signature of Applicant	Date
	

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AND FINANCIAL REGULATION
STATE BOARD OF EXAMINERS OF PSYCHOLOGISTS
35 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0035
TEL:(207)624-8603 – FAX:(207)624-8637

VERIFICATION OF SUPERVISED EXPERIENCE

Return this completed form directly to the applicant, not the Board.

Name and Address of Applicant:		
City:	State:	Zip Code:
The following section is to be completed by supervisor only		
Name of Facility:	Number of Professional Staff:	
Patient (client/resident) Population: Number: Type:		
Describe type of services provided at facility:		
Describe Applicant's Duties and Functions:		

** Please review Board Rules Chapter 5 section 2 regarding Supervised Experience requirements. **

Beginning date (MM/DD/YYYY) of Supervision _____ End Date _____

The following questions are to be answered by the Supervisor:

1. Were you licensed or certified as a psychologist in the state where the supervision occurred?
   ☐ Yes ☐ No
2. Did the pre-degree supervision consist of an average of a minimum of at least 16 hours but not more than 40 hours per week? ☐ Yes ☐ No If no, list hours of supervision _____ per week
3. Did the pre-degree supervision consist of a minimum of 3 hours per week, with one hour devoted to face-to-face individual supervision and the remaining 2 hours devoted to additional learning activities? ☐ Yes ☐ No If no, list face to face _____ hours and additional learning activities _____hours weekly.

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VERIFICATION OF SUPERVISED EXPERIENCE — Page 2
Return this completed form directly to the applicant, not the Board.

5. The Supervised experience did not include work experience earned in connection with practica for which academic credit has been awarded? ☐ Yes ☐ No if no, please describe academic credit awarded _____

_____

6. Did you provide at least two hours per week of learning activity supervision? ☐ Yes ☐ No

7. Was the supervised training completed with 24 months? ☐ Yes ☐ No

8. Did any of the hours described here accumulate while supervisee was functioning in a professional capacity not directly under your responsibility? ☐ Yes ☐ No

9. Was this supervisee's performance satisfactory? If not, please explain in detail on a separate sheet of paper. ☐ Yes ☐ No

If you answered NO to any of the above please provide a detailed explanation

_____

_____

_____

_____

10. What was the nature of the supervisee's duties while you were supervisor? _____

_____

_____

11. Total Number of hours worked while under my direct supervision: _____

I the supervisor, of the above named applicant is certifying the information provided on this form is verifiable, factual and accurate.

Print Name: **License Number:**

Signature: **Date:**

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PROFESSIONAL REFERENCE FORM

The completed form must accompany your application.

In accordance with Chapter 3, section 1(3)(A)(3) of the Board's rules, applicants must provide **three (3) reference letters** from qualified professionals who are familiar with the applicant's current work. At least two (2) of these references must be from a licensed Psychologist.

THIS FORM MUST BE RETURNED DIRECTLY TO THE APPLICANT AT THE ADDRESS BELOW:

Name of Applicant:		
Address:		
City:	State:	Zip Code:
The following section is to be completed by the professional providing the reference.		
Name:		
Address:		
City:	State:	Zip Code:

Telephone:	Email Address:
Professional License Type:	License # and State Issued:
License Expiration Date:	Highest Educational Degree:
Educational Institution:	Date Degree Conferred:
At the time of your professional relationship, what position did the applicant hold?	

What duties and functions did the applicant perform? Check all that apply.	□ Assessment/Evaluation □ Adults □ Children □ Psychotherapy/Counseling □ Adults □ Children □ Group Therapy □ Research □ Family/Marital Therapy □ Teaching □ Supervision of Others □ Case Presentations □ In Service Training □ Consultation with_____ □ Other, specify		
Was the frequency and intensity of the supervision?	□ Hours per week	Or	□ Hours per client/patient

Did you personally supervise this person? □ YES □ NO
If not, in what capacity did you know the applicant?

How many hours per week did the applicant do professional work relevant to this application?	Hours per week	For how long?
How would you rate the quality of this person's clinical work? (Check One)	□ Excellent □ Acceptable □ Unusually high □ Average Marginal Poor □ Better than average	

In your opinion, does this person have: (Check if yes; leave blank if no)

- □ High moral and ethical standards
- □ Sense of commitment to client/patient welfare
- □ Knowledge of own limits, and willingness to function within them
- □ Personal problems that would significantly impair his/her functioning
- □ Significant deficiencies in training, such that a license for the general practice of psychology should be restricted or denied

To the best of your knowledge, has the applicant (check if yes, leave blank if no):

- □ Completed an accredited and adequate graduate program
- □ Obtained a Master's degree
- □ Obtained a Doctoral degree
- □ Completed a graduate program in psychology
- □ Sufficient knowledge of basic science of psychology
- □ Sufficient knowledge of applied/professional area of psychology

Would you have any reservations about this person being licensed for the general practice of psychology? □ YES □ NO If yes, please explain.

Please list any additional comments that would be helpful to the Board.

Supervisor's Signature	Date

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THIS FORM MUST BE RETURNED DIRECTLY TO THE APPLICANT AT THE ADDRESS BELOW:

Name of Applicant:		
Address:		
City:	State:	Zip Code:
The following section is to be completed by the professional providing the reference.		
Name:		
Address:		
City:	State:	Zip Code:

Telephone:	Email Address:
Professional License Type:	License # and State Issued:
License Expiration Date:	Highest Educational Degree:
Educational Institution:	Date Degree Conferred:
At the time of your professional relationship, what position did the applicant hold?	

What duties and functions did the applicant perform? Check all that apply.	□ Assessment/Evaluation □ Psychotherapy/Counseling □ Group Therapy □ Family/Marital Therapy □ Supervision of Others □ In Service Training □ Consultation with_____ □ Other, specify	□ Adults □ Children □ Adults □ Children □ Research □ Teaching □ Case Presentations	
Was the frequency and intensity of the supervision?	□ Hours per week	Or	□ Hours per client/patient

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If not, in what capacity did you know the applicant?

How many hours per week did the applicant do professional work relevant to this application?	Hours per week	For how long?

How would you rate the quality of this person's clinical work? (Check One)	□ Excellent □ Unusually high □ Better than average	□ Acceptable □ Average Marginal Poor

In your opinion, does this person have: (Check if yes; leave blank if no)

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- □ Obtained a Master's degree
- □ Obtained a Doctoral degree
- □ Completed a graduate program in psychology
- □ Sufficient knowledge of basic science of psychology
- □ Sufficient knowledge of applied/professional area of psychology

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Supervisor's Signature	Date

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THIS FORM MUST BE RETURNED DIRECTLY TO THE APPLICANT AT THE ADDRESS BELOW:

Name of Applicant:		
Address:		
City:	State:	Zip Code:
The following section is to be completed by the professional providing the reference.		
Name:		
Address:		
City:	State:	Zip Code:

Telephone:	Email Address:
Professional License Type:	License # and State Issued:
License Expiration Date:	Highest Educational Degree:
Educational Institution:	Date Degree Conferred:
At the time of your professional relationship, what position did the applicant hold?	

What duties and functions did the applicant perform? Check all that apply.	□ Assessment/Evaluation □ Psychotherapy/Counseling □ Group Therapy □ Family/Marital Therapy □ Supervision of Others □ In Service Training □ Consultation with_____ □ Other, specify	□ Adults □ Children □ Adults □ Children □ Research □ Teaching □ Case Presentations	
Was the frequency and intensity of the supervision?	□ Hours per week	Or	□ Hours per client/patient
Did you personally supervise this person? □ YES □ NO If not, in what capacity did you know the applicant?			
How many hours per week did the applicant do professional work relevant to this application?	Hours per week		For how long?
How would you rate the quality of this person's clinical work? (Check One)	□ Excellent □ Unusually high □ Better than average	□ Acceptable □ Average Marginal Poor	

In your opinion, does this person have: (Check if yes; leave blank if no)

- □ High moral and ethical standards
- □ Sense of commitment to client/patient welfare
- □ Knowledge of own limits, and willingness to function within them
- □ Personal problems that would significantly impair his/her functioning
- □ Significant deficiencies in training, such that a license for the general practice of psychology should be restricted or denied

To the best of your knowledge, has the applicant (check if yes, leave blank if no):

- □ Completed an accredited and adequate graduate program
- □ Obtained a Master's degree
- □ Obtained a Doctoral degree
- □ Completed a graduate program in psychology
- □ Sufficient knowledge of basic science of psychology
- □ Sufficient knowledge of applied/professional area of psychology

Would you have any reservations about this person being licensed for the general practice of psychology? □ YES □ NO If yes, please explain.

Please list any additional comments that would be helpful to the Board.

Supervisor's Signature	Date

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Application to Provide Intervention Services Under Supervision

Applicant's Name	
Contact Address	Street
	City/State/ZIP

Please list intervention privileges being requested:

_____

_____

_____

_____

_____

On a separate sheet of paper provide the following information in the format given below.

1. A detailed description of the type of service(s), population and settings you propose to provide.
2. List relevant education and training. Include names of teachers and supervisors and documentation of your work.
3. List relevant experience, and include names of supervisor(s).
4. List the name and address of two licensed psychologists who are familiar with your work in the area for which privileges are sought.

_____ _____

Applicant's Signature Date

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AUGUSTA, MAINE 04333-0035
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Supervisor's Letter of Agreement to Provide Supervision For Intervention Services of a Psychological Examiner

This form must accompany Application to Provide Intervention Services under Supervision

I,_____, agree to provide supervision to

_____for intervention privileges of

_____

In making this agreement, I agree to abide by the rules established by the State Board of Examiners of Psychologists as stated in the Rules. I accept responsibility for both myself and the psychological examiner to ensure that the scope, limits, and supervised nature of intervention services are accurately communicated to the public. I am responsible for all intervention services provided by the supervisee, and that it is my responsibility to protect the welfare of the client and the supervisee.

I further understand that the Board shall determine whether I am qualified by education, training and experience to supervise the specific intervention services. This will be done on a basis of the Board file and any additional information that I submit.

If, for any reason, I must terminate my supervisory agreement or alter the conditions, I must inform the Board in writing of the change.

I have agreed to provide a minimum of _____hour(s) of supervision for every _____(s) of intervention.

Supervisor's Signature _____ License #_____

As a psychological examiner requesting the intervention privileges, I accept the terms of the above agreement and fully agree to abide by the State Board of Examiners of Psychologists laws and rules.

FOR OFFICE USE ONLY

The Board ☐ approves ☐ denies the application for intervention services.

Date of action by the Board: _____

Reason for denial: _____

_____

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
STATE BOARD OF EXAMINERS OF PSYCHOLOGISTS
35 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0035
TEL:(207)624-8603 – FAX:(207)624-8637

ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission

Name: _____

Address: _____

Telephone #: _____ Social Security Number: _____

Accommodations Requested for the _____ Examination.

Disability _____

Please check all that apply

☐ Accessible Testing Site
☐ Separate Testing Site
☐ Braille
☐ Large Print
☐ Tape
☐ Reader as Accommodation for Visual Impairment
☐ Scribe/Amanuensis as Accommodation for Visual or Motor Impairment
☐ Reader as Accommodation for Learning Disability
☐ Scribe/Amanuensis as Accommodation for Learning
☐ Sign Language Interpreter
☐ Extended Time
    ☐ Time-and-a-half
    ☐ Double time
    ☐ More than double time (specify): _____
☐ Use of Computer or other adaptive equipment (specify): _____
☐ Other:_____

_____

Signed and dated: _____

DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ **since** _____ **in**
(Test applicant) (Date)

my capacity as a _____.
(Professional Title)

This applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, providing the following should accommodate him/ her: (check all that apply):

☐ Accessible Testing Site
☐ Separate Testing Site
☐ Braille
☐ Large Print
☐ Tape
☐ Reader as Accommodation for Visual Impairment
☐ Scribe/Amanuensis as Accommodation for Visual or Motor Impairment
☐ Reader as Accommodation for Learning Disability
☐ Scribe/Amanuensis as Accommodation for Learning
☐ Sign Language Interpreter
☐ Extended Time
    ☐ Time-and-a-half
    ☐ Double time
    ☐ More than double time (specify): _____
☐ Use of Computer or other adaptive equipment (specify): _____
☐ Other:_____

_____

Signed: _____ Title: _____

Date: _____ License # (if applicable): _____

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